

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>104</u>	Skilled (SNF)	<u>104</u>	<u>37,960</u>	1
2	<u>208</u>	Skilled Pediatric (SNF/PED)	<u>208</u>	<u>75,920</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>312</u>	TOTALS	<u>312</u>	<u>113,880</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,298</u>	<u>1,696</u>	<u>9,563</u>	<u>23,557</u>	8
9	SNF/PED					9
10	ICF	<u>52,136</u>	<u>7,174</u>	<u>7,399</u>	<u>66,709</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>64,434</u>	<u>8,870</u>	<u>16,962</u>	<u>90,266</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.26%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 8/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 08/01/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 33 and days of care provided 5,887

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2001 Ending: 12/31/2001
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	516,992	39,709	25,326	582,027		582,027	1,381	583,408			1
2	Food Purchase		379,281		379,281		379,281	(1,206)	378,075			2
3	Housekeeping	407,552	60,421	0	467,973		467,973	(7,805)	460,168			3
4	Laundry	136,581	31,645	8,720	176,946		176,946	(907)	176,039			4
5	Heat and Other Utilities			186,167	186,167		186,167	0	186,167			5
6	Maintenance	72,327	52,846	63,388	188,561		188,561	1,330	189,891			6
7	Other (specify):*			80,108	80,108		80,108	0	80,108			7
8	TOTAL General Services	1,133,452	563,902	363,709	2,061,063	0	2,061,063	(7,207)	2,053,856			8
	B. Health Care and Programs											
9	Medical Director	0		26,440	26,440		26,440	0	26,440			9
10	Nursing and Medical Records	2,932,049	195,582	218,349	3,345,980		3,345,980	64,968	3,410,948			10
10a	Therapy	166,597		40,908	207,505		207,505	0	207,505			10a
11	Activities	249,669	4,773	3,152	257,594		257,594	(1,776)	255,818			11
12	Social Services	178,041		6,086	184,127		184,127	0	184,127			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			6,444	6,444		6,444	0	6,444			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	3,526,356	200,355	301,379	4,028,090	0	4,028,090	63,192	4,091,282			16
	C. General Administration											
17	Administrative	152,497		979,459	1,131,956		1,131,956	(949,211)	182,745			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			474,905	474,905		474,905	12,091	486,996			19
20	Dues, Fees, Subscriptions & Promotions			115,839	115,839		115,839	(81,420)	34,419			20
21	Clerical & General Office Expenses	317,851	60,183	85,662	463,696		463,696	170,555	634,251			21
22	Employee Benefits & Payroll Taxes			972,503	972,503		972,503	0	972,503			22
23	Inservice Training & Education			9,716	9,716		9,716	0	9,716			23
24	Travel and Seminar			371	371		371	17,365	17,736			24
25	Other Admin. Staff Transportation			11,358	11,358		11,358	0	11,358			25
26	Insurance-Prop.Liab.Malpractice			22,088	22,088		22,088	235,687	257,775			26
27	Other (specify):*			173,500	173,500		173,500	(173,500)	0			27
28	TOTAL General Administration	470,348	60,183	2,845,401	3,375,932	0	3,375,932	(768,433)	2,607,499			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,130,156	824,440	3,510,489	9,465,085	0	9,465,085	(712,448)	8,752,637			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			79,676	79,676		79,676	163,615	243,291			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			158,600	158,600		158,600	354,962	513,562			32
33	Real Estate Taxes			396,526	396,526		396,526	0	396,526			33
34	Rent-Facility & Grounds			1,388,874	1,388,874		1,388,874	(1,376,395)	12,479			34
35	Rent-Equipment & Vehicles			33,620	33,620		33,620	11,233	44,853			35
36	Other (specify):* STORAGE			3,444	3,444		3,444	0	3,444			36
37	TOTAL Ownership			2,060,740	2,060,740	0	2,060,740	(846,585)	1,214,155			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		237,596	239,272	476,868		476,868	0	476,868			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			170,820	170,820		170,820	0	170,820			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	237,596	410,092	647,688	0	647,688	0	647,688			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,130,156	1,062,036	5,981,321	12,173,513	0	12,173,513	(1,559,033)	10,614,480			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,723)	30		9
10	Interest and Other Investment Income	(384)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,206)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(1,117)	21		18
19	Entertainment	(61,981)	20		19
20	Contributions	(2,120)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(3,694)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(173,500)	27		24
25	Fund Raising, Advertising and Promotional	(8,006)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,454)	20		28
29	Other-Attach Schedule SEE PAGE 5A	48,268			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (225,917)		\$ 0	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,333,116)	PG 6&6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,333,116)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,559,033)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0044164

Report Period Beginning:01/01/2001

Ending:12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1803	6	1
2	VACATION ACCRUAL	1,381	1	2
3	VACATION ACCRUAL	(7,805)	3	3
4	VACATION ACCRUAL	(907)	4	4
5	VACATION ACCRUAL	(473)	6	5
6	VACATION ACCRUAL	48,355	10	6
7	VACATION ACCRUAL	(1,776)	11	7
8	VACATION ACCRUAL	4,922	17	8
9	VACATION ACCRUAL	2,768	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	48,268		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTWOOD CARE CENTRE# 0044164

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	1,381	0	0	0	0	0	0	0	0	0	0	1,381	1
2	Food Purchase	(1,206)	0	0	0	0	0	0	0	0	0	0	(1,206)	2
3	Housekeeping	(7,805)	0	0	0	0	0	0	0	0	0	0	(7,805)	3
4	Laundry	(907)	0	0	0	0	0	0	0	0	0	0	(907)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,330	0	0	0	0	0	0	0	0	0	0	1,330	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,207)	0	0	0	0	0	0	0	0	0	0	(7,207)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	48,355	16,613	0	0	0	0	0	0	0	0	0	64,968	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,776)	0	0	0	0	0	0	0	0	0	0	(1,776)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	46,579	16,613	0	0	0	0	0	0	0	0	0	63,192	16
	C. General Administration													
17	Administrative	4,922	(954,133)	0	0	0	0	0	0	0	0	0	(949,211)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,694)	8,060	7,725	0	0	0	0	0	0	0	0	12,091	19
20	Fees, Subscriptions & Promotions	(84,561)	3,141	0	0	0	0	0	0	0	0	0	(81,420)	20
21	Clerical & General Office Expenses	1,651	168,904	0	0	0	0	0	0	0	0	0	170,555	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	17,365	0	0	0	0	0	0	0	0	0	17,365	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	5,576	230,111	0	0	0	0	0	0	0	0	235,687	26
27	Other (specify):*	(173,500)	0	0	0	0	0	0	0	0	0	0	(173,500)	27
28	TOTAL General Administration	(255,182)	(751,087)	237,836	0	0	0	0	0	0	0	0	(768,433)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(215,810)	(734,474)	237,836	0	0	0	0	0	0	0	0	(712,448)	29

Summary B

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		FIRST HEALTH CARE ASSOCIATES, LTD. (DIVISION OF FHC ENTERPRISE, INC.)	ROSEMONT	MANAGEMENT/ CONSULTANT
				CRESTWOOD HEIGHTS NURSING CENTRE		
					ROSEMONT, ILL	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	\$	FHC ENTERPRISES INC.		\$ 16,613	\$ 16,613	1
2	V	17	ADMINISTRATIVE	979,459	MR. BELLOWS OWNS 22% OF THIS FACILITY		25,326	(954,133)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		8,060	8,060	3
4	V	20	DUES & SUBSCRIPTIONS		" "		3,141	3,141	4
5	V	21	CLERICAL		" "		168,904	168,904	5
6	V	24	TRAVEL		" "		17,365	17,365	6
7	V	26	INSURANCE		" "		5,576	5,576	7
8	V	30	DEPRECIATION		" "		8,924	8,924	8
9	V	34	RENT		" "		12,479	12,479	9
10	V	35	RENT-EQUIPMENT		" "		11,233	11,233	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 979,459			\$ 277,621	\$ * (701,838)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 1,388,874	CRESTWOOD HEIGHTS NURSING CENTRE		\$	\$ (1,388,874)	15
16	V	19	ACCOUNTING FEES		" "		7,725	7,725	16
17	V	19	LEGAL		" "				17
18	V	19	OTHER PROFESSIONAL		" "				18
19	V	26	GENERAL INSURANCE		" "		206,274	206,274	19
20	V	26	MORTGAGE INSURANCE		" "		23,837	23,837	20
21	V	30	DEPRECIATION - BLDG, IMP		" "		146,441	146,441	21
22	V	30	DEPRECIATION-EQUIP, FURN.		" "		17,973	17,973	22
23	V	32	AMORTIZATION - MTG COST		" "		3,245	3,245	23
24	V	32	MORTGAGE INTEREST		" "		352,101	352,101	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,388,874			\$ 757,596	\$ * (631,278)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								\$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	0.22	SEE ATTACHED	3.4	17.97	SALARY	25,326	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 25,326		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

#	0044164	Report Period Beginning:	01/01/2001	Ending:	2/31/2001
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Name of Related Organization	<u>FHC ENTERPRISES INC.</u>
Street Address	<u>10700 W. HIGGINS ROAD, STE. 300</u>
City / State / Zip Code	<u>ROSEMONT, IL 60018</u>
Phone Number	<u>(847) 296-9625</u>
Fax Number	<u>(847) 298-0824</u>

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10	NURSING	PATIENT DAYS	501,904	10	\$ 92,369	\$ 92,369	90,266	\$ 16,613	1
2	17	ADMINISTRATIVE	PATIENT DAYS	501,904	10	140,817	140,817	90,266	25,326	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	501,904	10	44,800		90,266	8,060	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	501,904	10	17,462		90,266	3,141	4
5	21	CLERICAL	PATIENT DAYS	501,904	10	130,659		90,266	23,506	5
6	21	CLERICAL	HOURS	1	1	145,398	145,398	1	145,398	6
7	24	TRAVEL	PATIENT DAYS	501,904	10	96,528		90,266	17,365	7
8	26	INSURANCE	PATIENT DAYS	501,904	10	30,995		90,266	5,576	8
9	30	DEPRECIATION	PATIENT DAYS	501,904	10	49,603		90,266	8,924	9
10	34	RENT	PATIENT DAYS	501,904	10	69,364		90,266	12,479	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	501,904	10	62,438		90,266	11,233	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 880,433	\$ 378,584		\$ 277,621	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE						\$					\$	1
2	GMAC		X	MORTGAGE	\$84,053.00	9/97		4,897,900	4,752,916	09/32	7.3750	352,101	2
3	GMAC		X	LOAN COST	AMORT-35YRS			113,573	99,782			3,245	3
4													4
5													5
	Working Capital												
6	AMERICAN NATIONAL BANK		X	WORKING CAPITAL	DEMAND	VARIES		323,671	1,500,000	DEMAND	PRIME+	57,816	6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES		1,191,428	1,006,963	DEMAND	VARIES	91,117	7
8	LOAN FROM PARTNERS	X		WORKING CAPITAL	DEMAND	1231/99		100,000	126,848	DEMAND	0.0825	9,667	8
9	TOTAL Facility Related				\$84,053.00		\$	6,626,572	\$	7,486,509			9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	0	\$	0			14
15	TOTALS (line 9+line14)						\$	6,626,572	\$	7,486,509			15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</div>			
1. Real Estate Tax accrual used on 2000 report.		\$ 479,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 450,237	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (29,163)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 457,429	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 31,740 For 19 99 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ (31,740)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 396,526	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996 463,218 8		
	1997 474,029 9		
	1998 481,940 10		
	1999 471,970 11		
	2000 450,237 12		
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL			
THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.			
		FOR OHF USE ONLY	
		13 FROM R. E. TAX STATEMENT FOR 2000 \$	13
		14 PLUS APPEAL COST FROM LINE 5 \$	14
		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CRESTWOOD CARE CENTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044164

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 28-03-303-011-0000	NURSING HOME	\$ 154,708.81	\$ 154,708.81
2. 28-03-303-012-0000	NURSING HOME	\$ 283,368.43	\$ 283,368.43
3. 28-03-303-021-0000	NURSING HOME	\$ 1,661.96	\$ 1,661.96
4. 28-03-303-022-0000	NURSING HOME	\$ 1,661.96	\$ 1,661.96
5. 28-03-303-023-0000	NURSING HOME	\$ 3,345.99	\$ 3,345.99
6. 28-03-303-024-0000	NURSING HOME	\$ 5,489.96	\$ 5,489.96
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 450,237.11	\$ 450,237.11

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	75,000	1972	\$ 294,389	1
2	SEWER		1978	41,363	2
3	TOTALS	75,000		\$ 335,752	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	312		1974	1974	\$ 2,091,708	\$ 26,548	35	\$ 59,763	\$ 33,215	\$ 1,668,384	4
5			1980	1980	3,400		35	100	100	2,150	5
6	SEC 754 AJ			1992	584,054	18,541	31.5	18,541		176,142	6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE										9
10	REMODELING			1977	34,163		10			34,163	10
11	REMODELING			1980	12,383		10			12,383	11
12	IMPROVEMENTS			1984	38,466	1,756	20		(1,756)	38,466	12
13	IMPROVEMENTS			1985	18,271	934	10		(934)	18,271	13
14	IMPROVEMENTS			1985	1,200	62	20	60	(2)	990	14
15	IMPROVEMENTS			1985	32,506	1,691	15		(1,691)	32,506	15
16	IMPROVEMENTS			1986	76,557	3,982	20	3,828	(154)	59,328	16
17	IMPROVEMENTS			1986	16,943	881	10		(881)	16,943	17
18	IMPROVEMENTS			1986	1,559	81	25	62	(19)	961	18
19	IMPROVEMENTS			1987	23,951	761	20	1,198	437	17,362	19
20	IMPROVEMENTS			1987	22,863	726	20	1,143	417	16,574	20
21	IMPROVEMENTS			1988	20,627	1,406	20	1,031	(375)	9,757	21
22	IMPROVEMENTS			1989	35,057	432	31.5	1,113	681	14,292	22
23	IMPROVEMENTS			1990	50,320	1,598	31.5	1,598		17,916	23
24	IMPROVEMENTS			1991	53,090	1,684	31.5	1,684		17,398	24
25	IMPROVEMENTS			1992	53,668	1,704	31.5	1,704		16,220	25
26	IMPROVEMENTS			1992	51,711	3,447	31.5	3,447		32,316	26
27	IMPROVEMENTS			1993	42,479	1,090	15	1,090		9,020	27
28	IMPROVEMENTS			1993	78,601	2,495	39	2,495		21,875	28
29	IMPROVEMENTS			1994	193,211	7,026	27.5	7,026		48,187	29
30	FIRE ALARM SYSTEMS			1995	19,476	708	27.5	708		4,659	30
31	ELEVATOR REHAB			1995	57,000	2,072	27.5	2,072		13,118	31
32	NURSES CALL STATION			1995	6,318	230	27.5	230		1,455	32
33	DINING ROOM AIR CONDITIONING SYSTEM			1995	9,370	341	27.5	341		2,074	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number **CRESTWOOD CARE CENTRE**# **0044164**

Report Period Beginning:

01/01/2001 Ending: 12/31/2001**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	COOLING TOWER REPLACEMENT	1995	\$ 15,650	\$ 569	27.5	\$ 569	\$	\$ 3,459	37
38	HAND RAILS/TILING/ROOF	1996	103,547	3,765	27.5	3,765		21,010	38
39	HAND RAILS/TILING/ROOF	1996	877	32	27.5	32		170	39
40	OUR TOWN	1996	61,800	2,247	27.5	2,247		10,854	40
41	REMODELING EXISTING STRUCTURE/SMOKE DOORS	1997	65,677	2,390	27.5	2,390		11,240	41
42	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1997	406,833	14,794	27.5	14,794		68,738	42
43	FIRE EXIT/REHAB/ROOF/OUR TOWN/WALLCOVERING	1997	44,213	1,607	27.5	1,607		7,278	43
44	WINDOW/OUR TOWN/WALLCOVERING/FLOORS	1997	76,586	2,784	27.5	2,784		12,112	44
45	OUR TOWN	1998	32,000	1,164	27.5	1,164		4,607	45
46	ELECTRICAL WIRING FOR LAUNDRY AREA	1998	4,400	160	27.5	160		633	46
47	REMODELING - FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	35,000	1,273	27.5	1,273		5,039	47
48	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	900	33	27.5	33		130	48
49	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	9,604	349	27.5	349		1,382	49
50	AIR CONDITIONING SYSTEM	1998	17,900	651	27.5	651		2,468	50
51	ROOF REPAIRS	1998	2,790	101	27.5	101		383	51
52	BOILER VALVE	1998	5,450	198	27.5	198		602	52
53	WALLCOVERING	1999	2,206	80	27.5	80		307	53
54	METAL DOORS/OAK DOORS AND LOCKSETS	1999	6,267	228	27.5	228		502	54
55	OVERHANG WORK	1999	4,150	151	27.5	151		321	55
56	REMODEL - NURSES STATIONS	2000	25,135	914	27.5	914		1,409	56
57	A/C COMPRESSOR	2000	27,970	1,017	27.5	1,017		1,483	57
58	ROOF WORK	2000	11,384	414	27.5	414		535	58
59	REMODELING-DIALYSIS ROOM-PLUMBING, ELECTRICAL	2000	23,240	845	27.5	845		1,021	59
60	REMODEL - NURSES STATIONS	2000	10,730	390	27.5	390		439	60
61	CLOSET DOORS - 2, 3, AND 4TH FLOOR NURSES STATIONS	2001	1,900	66	27.5	66		66	61
62	PAINT LOCKER ROOMS AND RESIDENT BATHROOMS	2001	1,050	33	27.5	33		33	62
63	RENOVATE - 3A, 4B, AND 4A UTILITY ROOM CABINETS	2001	6,405	165	27.5	165		165	63
64	WANDERING ALERT SYSTEM - ALZHEIMERS UNIT	2001	17,525	398	27.5	398		398	64
65	DRYWALL AND PAINT - ROOM 226 AND BATHROOM	2001	1,883	37	27.5	37		37	65
66	ANTENNA SYSTEMS	2001	16,745	279	27.5	279		279	66
67	REPLACE 38 RESIDENT ROOM DOORS AND FIRE DOORS	2001	10,336	47	27.5	47		47	67
68	WANDERING ALERT SYSTEM - FIRST FLOOR	2001	13,650	21	27.5	21		21	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,692,755	\$ 117,398		\$ 146,436	\$ 29,038	\$ 2,460,078	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$4,692,755	\$117,398		\$146,436	\$29,038	\$2,460,078	1
2									2
3	REPLACE FIRST FLOOR DOUBLE DOORS	2001	3,150	5	27.5	5		5	3
4									4
5									5
6			ADJ TO SL	29,038			(29,038)		6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,695,905	\$146,441		\$146,441	\$0	\$2,460,083	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$689,921	\$71,640	\$67,725	\$(3,915)	3-10 YRS	\$341,382	71
72	Current Year Purchases	40,221	8,036	2,228	(5,808)	3-10 YRS	2,228	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	617,339	26,897	26,897	0		585,995	74
75	TOTALS	\$1,347,481	\$106,573	\$96,850	\$(9,723)		\$929,605	75

D. Vehicle Depreciation (See instructions.)*										
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$ 0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	80

E. Summary of Care-Related Assets		1	2	
		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,379,138	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 253,014	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 243,291	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,723)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,389,688	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress			
	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YESNO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: YESNO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2002 | \$ |
| 13. | /2003 | \$ |
| 14. | /2004 | \$ |

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YESNO
16. Rental Amount for movable equipment: \$33,620Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 103,564	\$		\$ 103,564	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			11,822			11,822	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			119,554			119,554	4
5	Physician Care	39-3	visits			4,332			4,332	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				151,522		151,522	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTALS, I.V. THERAPY Other (specify):	39-2					86,074		86,074	13
14	TOTAL			\$		\$ 239,272	\$ 237,596		\$ 476,868	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 80,178	\$ 349,122	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 78,429)	3,086,212	3,086,212	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,811	2,811	5
6	Prepaid Insurance	55,185	347,771	6
7	Other Prepaid Expenses	16,265	16,265	7
8	Accounts Receivable (owners or related parties)	61,726	2,892,868	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		254,177	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,302,377	\$ 6,949,226	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		477,487	13
14	Buildings, at Historical Cost		2,095,108	14
15	Leasehold Improvements, at Historical Cost		2,502,361	15
16	Equipment, at Historical Cost	771,292	1,782,860	16
17	Accumulated Depreciation (book methods)	(609,531)	(3,943,453)	17
18	Deferred Charges		99,782	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		307,181	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 161,761	\$ 3,321,326	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,464,138	\$ 10,270,552	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 451,476	\$ 686,334	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	607,708	607,708	28
29	Short-Term Notes Payable	2,506,963	2,506,963	29
30	Accrued Salaries Payable	193,927	193,927	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,731	23,731	31
32	Accrued Real Estate Taxes(Sch.IX-B)		457,429	32
33	Accrued Interest Payable	112	112	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>MANAGEMENT FEES</u>	496,106	496,106	36
37	<u>DUE TO DPA</u>	221,203	221,203	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,501,226	\$ 5,193,513	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	126,848	126,848	39
40	Mortgage Payable		4,752,916	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 126,848	\$ 4,879,764	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,628,074	\$ 10,073,277	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,163,936)	\$ 197,275	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,464,138	\$ 10,270,552	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,618,026)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,618,026)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	454,090	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 454,090	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,163,936)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **CRESTWOOD CARE CENTRE**# **0044164**Report Period Beginning: **01/01/2001**Ending: **12/31/2001****XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.****1**

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,627,213	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,627,213	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	384	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 384	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	6	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,627,603	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,061,063	31
32	Health Care	4,028,090	32
33	General Administration	3,375,932	33
	B. Capital Expense		
34	Ownership	2,060,740	34
	C. Ancillary Expense		
35	Special Cost Centers	476,868	35
36	Provider Participation Fee	170,820	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,173,513	40
41	Income before Income Taxes (line 30 minus line 40)**	454,090	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 454,090	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,008	1,430	\$ 44,283	\$ 30.97	1
2	Assistant Director of Nursing	3,438	4,327	133,998	30.97	2
3	Registered Nurses	38,041	42,650	1,016,606	23.84	3
4	Licensed Practical Nurses	20,185	22,259	420,823	18.91	4
5	Nurse Aides & Orderlies	102,213	113,769	1,160,843	10.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,548	2,944	37,675	12.80	7
8	Rehab/Therapy Aides	8,544	9,651	128,922	13.36	8
9	Activity Director	4,476	5,033	79,834	15.86	9
10	Activity Assistants	13,954	15,348	169,835	11.07	10
11	Social Service Workers	10,303	11,634	178,041	15.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	12,640	14,277	195,897	13.72	14
15	Cook Helpers/Assistants	34,351	37,708	321,095	8.52	15
16	Dishwashers					16
17	Maintenance Workers	6,106	6,634	72,327	10.90	17
18	Housekeepers	39,476	43,690	407,552	9.33	18
19	Laundry	15,212	16,516	136,581	8.27	19
20	Administrator	173	254	66,598	262.20	20
21	Assistant Administrator	1,925	2,479	85,899	34.65	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,009	14,461	317,851	21.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	14,290	16,385	155,496	9.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	341,892	381,449	\$ 5,130,156 *	\$ 13.45	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	416	\$ 24,692	1-3	35
36	Medical Director	486	26,440	9-3	36
37	Medical Records Consultant	64	2,896	10-3	37
38	Nurse Consultant	1,206	42,742	10-3	38
39	Pharmacist Consultant	1,380	3,600	10-3	39
40	Physical Therapy Consultant	319	17,987	10a-3	40
41	Occupational Therapy Consultant	360	22,724	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	2	197	10a-3	43
44	Activity Consultant	48	3,052	11-3	44
45	Social Service Consultant	100	6,086	12-3	45
46	Other(specify) <u>PSYCHO-SOCIAL</u>	16	1,040	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,397	\$ 151,456		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	74	\$ 2,998		50
51	Licensed Practical Nurses	4,007	162,978		51
52	Nurse Aides	15	227		52
53	TOTAL (lines 50 - 52)	4,096	\$ 166,203		53

XIX. SUPPORT SCHEDULES								
A. Administrative Salaries			Ownership %	D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Amount		Description	Amount	Description	Amount	
JEANETTE FOX EKSTROM	ADMIN	\$ 66,598	Workers' Compensation Insurance	\$ 94,734	IDPH License Fee	\$		
DIANE WALKER	ASST ADMIN	85,899	Unemployment Compensation Insurance	39,129	Advertising: Employee Recruitment	10,657		
			FICA Taxes	390,817	Health Care Worker Background Check	1,042		
			Employee Health Insurance	394,101	(Indicate # of checks performed 87)			
			Employee Meals	0	MARKETING/ADV/PROMO	82,441		
			Illinois Municipal Retirement Fund (IMRF)*		RELATED PARTY	3,141		
			EMPLOYEE BENEFITS - OTHER	34,442	CONTRIBUTIONS	2,120		
			EMPLOYEE PHYSICAL EXAMS	740	DUES & SUBSCRIPTIONS	18,755		
			PENSION/PROFIT SHARING PLANS	18,540	LICENSES & PERMITS	824		
TOTAL (agree to Schedule V, line 17, col. 1)					LESS: CONTRIBUTIONS	(2,120)		
(List each licensed administrator separately.)			\$ 152,497		Less: Public Relations Expense	(61,981)		
B. Administrative - Other					Non-allowable advertising	(8,006)		
					Yellow page advertising	(12,454)		
Description		Amount						
FIRST HEALTHCARE	MANAGEMENT FEES	\$ 979,459						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 979,459					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount
		\$				\$	Out-of-State Travel	\$
							In-State Travel	
								371
							RELATED PARTY	17,365
							Seminar Expense	
								0
SEE SCHEDULE ATTACHED		474,905					Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 474,905				TOTAL	\$ 17,736

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	\$ 3,207	3	\$ 535	\$ 1,069	\$ 1,069	\$ 534	\$	\$	\$	\$	\$
2	PAINT/DECORATING	2000	7,387	3			1,231	2,462	2,462	1,232			
3	PAINT/DECORATING	2001	1,790	3			298	597	597	298			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 12,384		\$ 535	\$ 1,069	\$ 2,598	\$ 3,593	\$ 3,059	\$ 1,530	\$	\$	\$

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL COUNCIL ON LTC \$16921
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,502 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 170,820
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	24,692
	REPAIRS & MAINTENANCE	634
		0
		25,326
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	8,720
		0
		8,720
5	HEAT & OTHER UTILITIES	
	GAS HEAT	89,513
	ELECTRICITY	79,333
	WATER	17,321
	CABLE TV - LOBBY	0
		0
		186,167
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,815
	PAINTING & DECORATING	1,790
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	30,091
	ELEVATOR MAINTENANCE & REPAIR	11,374
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,345
	FIRE SERVICE	4,884
	DEFERRED MAINTENANCE	3,089
		0
		0
		63,388
7	OTHER	
	SCAVENGER	19,829
	SECURITY SERVICE	60,279
		80,108
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	26,440
		26,440

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	166,203
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	1,868
	PSYCHO-SOCIAL CONSULTANT XVIII B 46-2	1,040
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,896
	PHARMACY CONSULTANT XVIII B 39-2	3,600
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	42,742
		0
		0
		218,349
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	17,987
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	22,724
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	197
		40,908
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,052
	CLERGY	100
		3,152
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	3,250
	SOCIAL WORKER XVIII B 45-2	2,836
		0
		6,086
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	6,444
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	979,459
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	34,462
	ADMINISTRATIVE CONSULTANTS XIX C	88,153
	PROFESSIONAL FEES XIX C	352,290
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	474,905
	ENTERTAINMENT & MARKETING VI 19 XIX F	61,981
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	8,006
	EMPLOYEE WANT ADS XIX F	10,657
	CONTRIBUTIONS VI 20 XIX F	820
	DUES & SUBSCRIPTIONS XIX F	18,755
	LICENSES & PERMITS XIX F	824
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	12,454
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,300
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,042
21	CLERICAL & GENERAL OFFICE EXPENSES	115,839
	BANK CHARGES	12,356
	EQUIPMENT REPAIR & MAINTENANCE	18,446
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	1,117
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	688
	TELEPHONE	52,420
	MESSENGER SERVICE	635
		0
		85,662

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	390,817
	UNEMPLOYMENT COMPENSATION XIX D	39,129
	WORKERS COMPENSATION INSURANC XIX D	94,734
	HOSPITALIZATION INSURANCE XIX D	394,101
	EMPLOYEE BENEFITS - OTHER XIX D	34,442
	EMPLOYEE PHYSICAL EXAMS XIX D	740
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	18,540
	CHICAGO HEAD TAX XIX D	0
		972,503
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	9,716
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	371
		0
		0
		371
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	11,358
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	22,088
27	OTHER	
	BAD DEBTS VI 24	173,500
		0
		173,500

GRAND TOTAL COLUMN 3 OTHER

3,510,489

CRESTWOOD CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	379,281	PATIENT MEALS	270798
LESS SALES TAX	(1,206)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	380487	TOTAL MEALS/YEAR	270798
TOTAL PATIENT CENSUS	90,266	NET FOOD	380487
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	270798

TOTAL PATIENT MEALS	270798	COST PER MEAL	1.41
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

CRESTWOOD CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2001

INCOME PER F/S									11,766,365	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	4,028,090	972,503	922,809	176,946	961,308	2,403,429	170,820	2,060,740		5,130,156
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	4,651		7,992			20,977		(33,620)		
CABLE TV			0			0				
CONTRACT NURSING										166,203
INTEREST INCOME							(384)			
NET VENDING COMMISSIONS							(6)			
EMPLOYEE PHYSICAL EXAMS		(740)				740				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(979,459)		979,459		
RESIDENT TAX REBILLED - PVT										
BAD DEBTS						(173,500)	173,500			
DISCOUNTS LOST							0			
AMORT-COMP SOFTWARE								0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	(293,469)	0	0	0	0	293,469	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	(383,980)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	3,739,272	971,763	930,801	176,946	961,308	1,565,656	(40,050)	3,006,579	11,312,275	5,296,359
PER FINANCIAL STATEMENTS	3,739,272	971,763	930,801	176,946	961,308	1,565,656	(40,050)	3,006,579	454,090	5,296,359
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									454,090	

CRESTWOOD CARE CENTRE - COMPARISONS - 12/31/2001

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		113,880			114192			(312)	113880		
CENSUS DAYS		90,266			91073			(807)	97407		
OCCUPANCY %		79.26%			79.75%				85.53%		
SALARIES											
TOTAL General Services	8-1	1,133,452	10.68%	12.56	1091650	11.04%	11.99	41,802	1074488	10.90%	11.03
Social Services	12-1	178,041	1.68%	1.97	158366	1.60%	1.74	19,675	137795	1.40%	1.41
TOTAL Health Care and Programs	16-1	3,526,356	33.22%	39.07	3295601	33.34%	36.19	230,755	3450033	34.98%	35.42
Clerical & General Office Expenses	21-1	317,851	2.99%	3.52	287555	2.91%	3.16	30,296	258392	2.62%	2.65
TOTAL General Administration	28-1	470,348	4.43%	5.21	480887	4.86%	5.28	(10,539)	454647	4.61%	4.67
TOTAL Operation Expense	29-1	5,130,156	48.33%	56.83	4868138	49.25%	53.45	262,018	4979168	50.49%	51.12
ADJUSTED TOTALS											
Food	2-8	378,075	3.56%	4.19	381046	3.85%	4.18	(2,971)	387645	3.93%	3.98
Heat and Other Utilities	5-8	186,167	1.75%	2.06	166202	1.68%	1.82	19,965	146918	1.49%	1.51
Maintenance	6-8	189,891	1.79%	2.10	244969	2.48%	2.69	(55,078)	254725	2.58%	2.62
TOTAL General Services	8-8	2,053,856	19.35%	22.75	2079274	21.03%	22.83	(25,418)	2041763	20.70%	20.96
Administrative	17-8	182,745	1.72%	2.02	223904	2.27%	2.46	(41,159)	221688	2.25%	2.28
Directors Fees	18-8	0	0.00%	0.00				0			
Professional Services	19-8	486,996	4.59%	5.40	372375	3.77%	4.09	114,621	288162	2.92%	2.96
Fees, Subscriptions, Promotions	20-8	34,419	0.32%	0.38	52719	0.53%	0.58	(18,300)	27102	0.27%	0.28
License Fee-IDPA	Pg21	0	0.00%	0.00	200	0.00%	0.00	(200)	200	0.00%	0.00
License Fee-Other	Pg21	824	0.01%	0.01	11723	0.12%	0.13	(10,899)	4453	0.05%	0.05
Clerical & General Office Expenses	21-8	634,251	5.98%	7.03	597044	6.04%	6.56	37,207	581151	5.89%	5.97
Employee Benefits & Payroll Taxes	22-8	972,503	9.16%	10.77	862790	8.73%	9.47	109,713	879026	8.91%	9.02
Payroll Taxes	Pg21	429,946	4.05%	4.76	402968	4.08%	4.42	26,978	421212	4.27%	4.32
W/C Insurance	Pg21	94,734	0.89%	1.05	84110	0.85%	0.92	10,624	81419	0.83%	0.84
Health Insurance	Pg21	394,101	3.71%	4.37	307320	3.11%	3.37	86,781	330649	3.35%	3.39
Inservice Training & Education	23-8	9,716	0.09%	0.11	33209	0.34%	0.36	(23,493)	32979	0.33%	0.34
Travel and Seminar	24-8	17,736	0.17%	0.20	17156	0.17%	0.19	580	15373	0.16%	0.16
Other Admin. Staff Transportation	25-8	11,358	0.11%	0.13	9487	0.10%	0.10	1,871	16395	0.17%	0.17
Insurance-Prop.Liab.Malpractice	26-8	257,775	2.43%	2.86	188892	1.91%	2.07	68,883	119729	1.21%	1.23
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	2,607,499	24.57%	28.89	2357576	23.85%	25.89	249,923	2181605	22.12%	22.40
TOTAL Operation Expense	29-8	8,752,637	82.46%	96.96	8193573	82.89%	89.97	559,064	8155077	82.69%	83.72
Real Estate Taxes	33-3	396,526	3.74%	4.39	473902	4.79%	5.20	(77,376)	495662	5.03%	5.09
Real Estate Legal	Pg10	0	0.00%	0.00	17065	0.17%	0.19	(17,065)			
GRAND TOTAL COST	45-8	10,614,480	100.00%	117.59	9885136	100.00%	108.54	729,344	9861691	100.00%	101.24
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		3992877.903	37.62%	44.23	3852764	38.98%	42.30	140,114	3614297	36.65%	37.11

CRESTWOOD CARE CENTRE - DIAGNOSTICS - 12/31/2001

This report reflects a 365-day year.

Page 3 Column 3 - Other is completely scheduled.

Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.

Total Adj on Page 4 Line 45-7 = Page 5 Line 37.

Deferred maint. adj. on Page 5A Line 1 consists of 3593 from Page 22 and -1790 from Page 3 Line 6-3.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.

Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-355346

Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.

Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.

Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-173338

Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.

Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.

#VALUE!

Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.

Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.

Page 17 Assets = Liabilities & Capital.

Net income on Page 18 Line 7-1 = Page 19 Line 43-2.

Administrative Salaries on Page 3 Line 17-1 = Page 21-A.

Management fees on Page 3 Line 17-3 = Page 21-B.

Professional fees on Page 3 Line 19-3 = Page 21-C.

Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.

Dues, etc. on Page 3 Line 20-8 = Page 21-F.

Travel expenses on Page 3 Line 24-8 = Page 21-G.